Denial among Cancer Patients

Tips and traps

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SUMMARY

The coping mechanisms used by patients diagnosed with cancer play a role in their well-being and, therefore, influence their quality of life and possibly even their survival. We review the characteristics of one of these mechanisms, denial, and suggest an approach to dealing with denying patients.

RÉSUMÉ

Les mécanismes d'adaptation des patients chez qui on pose un diagnostic de cancer jouent un rôle au niveau de leur bien-être et influencent leur qualité de vie et même leur survie potentielle. L'article analyse les caractéristiques de l'un de ces mécanismes, la négation, et suggère une approche face aux patients aux prises avec cette négation.

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FOR BOTH OUR PATIENTS AND us, cancer is a frightening diagnosis that raises primordial fears of pain, bodily mutilation, dependence, and ultimately death. Not surprisingly, those diagnosed with cancer invoke any of a number of largely involuntary "defense mechanisms," including suppression, sublimation, regression, dissociation, and denial.[1,2]

Case histories

Case 1. The town's 72-year-old cab driver underwent a thoracotomy in Toronto for a pleural mass. Unresectable squamous cell lung carcinoma was found. The patient was duly informed that the cancer could not be removed, yet died a year later insisting to his last breath that "the doctor in Toronto took it all out."

Case 2. An 82-year-old widow of a paper mill labourer presented with a stone-hard, ulcerating breast lump. She was told by a consultant surgeon no less than twice that she had breast cancer and needed at least a lumpectomy. She remains fixed in denial a year later, insisting "he (the surgeon) said it was nothing serious."

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Case 3. A 72-year-old retired carpenter, living alone in a cheap hotel room, presented with weight loss, anemia, and persistent abdominal pain. There was a very strong family history of colon cancer. Despite being informed of the probability of colon cancer, he repeatedly did not show up for follow-up visits and diagnostic tests.

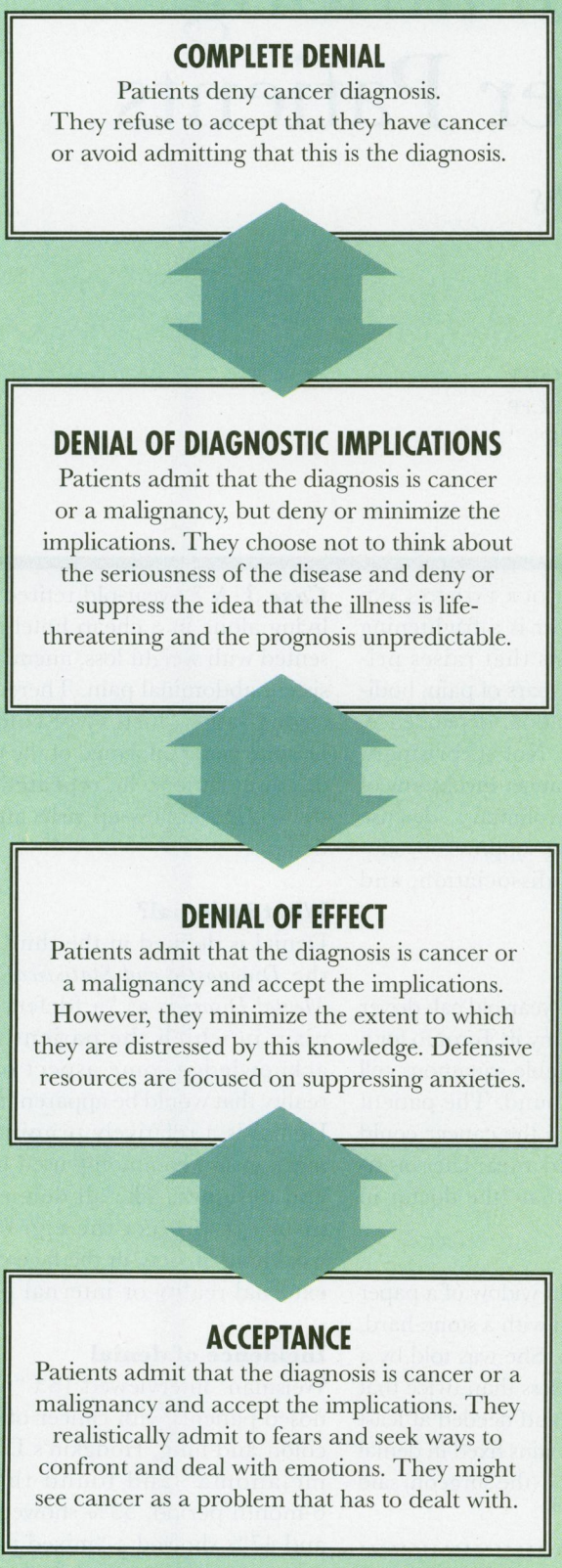
What is denial?

Denial is defined in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* as "a [defense] mechanism in which the patient refuses to acknowledge some aspect of external reality that would be apparent to others."[3] Denial is a relatively primitive defense mechanism, commonly used by children and designed, like all defense mechanisms, to protect the ego from overwhelming anxiety in the face of a painful external reality or internal perception.

Incidence of denial

Weisman[4] interviewed 163 "newly diagnosed patients with cancer of the breast, colon and lung, Hodgkin's Disease, and melanoma" and found that, over a 6-month period, 53% showed no denial and 47% showed a "mixed profile, fluctuating between varying degrees of acceptance and denial." Three patients were "persistent deniers." Interestingly,

Figure 1. **Levels of denial**



Adapted from Watson et al.[6]

two of these were relatively sick men with lung cancer like the patient in our first case history.

Manifestations of denial

As our case histories show, common manifestations of denial in our experience include:

- the patient not talking openly about the disease;
- the patient denying having ever having been told of the cancer;
- the patient saying that the cancer was completely removed by surgery, after being clearly informed it was not;
- the patient continuously using euphemisms, such as "inflammation" and "lump," rather than cancer or tumour; and
- the patient not returning for follow-up visits or treatments.

Course of denial

Denial is not an all-or-nothing phenomenon. It might pertain to all aspects of the patient's disease or only to certain parts. It could wax and wane with time; it might remit or be relentless over the entire spectrum of disease until death.[5] Persistent deniers appear to be rare. Only three of 162 patients in Weisman's series[4] and three of 200 patients in Kubler-Ross' series[2] persisted in denial until death. Watson et al[6] have proposed a scale for rating denial (*Figure 1*).

Denial might cause the patient to delay seeking therapy, notably in the case of a woman finding a breast lump. It might impair a patient's judgment at a time when he or she must make urgent therapeutic decisions. It could impair social relations. Some authors have suggested that it might ultimately jeopardize the prognosis.[7]

Differential diagnosis

Transient crisis reaction. Although not all patients show it, Kubler-Ross considers denial to be the normal first response to the knowledge of life-threatening disease. Hence, some early transient denial is probably normal. Like the dividing line between "normal" bereavement and "abnormal" depression, the line between normal and abnormal denial might be difficult to draw. Crary and Crary[8] have proposed that denial is abnormal when it significantly

impairs treatment and activities of daily living for more than a week or two.

Suppression. This differs from denial in that it is a voluntary decision on the part of the patient not to think of the disease: "I just try to put the thought out of my head." The patient might retreat into a stony silence that can be construed as denial. Friends and relatives sometimes confirm that the patient discusses the disease appropriately with them or that other actions, such as estate planning, are appropriate. With time and a trusting and empathetic physician, the person will often reveal that he or she is voluntarily suppressing thoughts of the disease. This corresponds partially to the better-known "bargaining" stage.[9]

Evaluating the denying patient

The following areas should be probed: capacity to understand the diagnosis, medical history, premorbid personality and psychological profile, the role of the family, and the consequences of the denial.

Capacity to understand the diagnosis. Consider the level of education, general functioning, and the patient's cultural attitude toward disease in general and cancer in particular. The patient might have been raised in a society that has a nihilistic view of physicians and that believes that cancer is either not to be discussed or that nothing can be done in the case of cancer except to go home and die. Some studies suggest that deniers are older and less educated than nondeniers, but this might simply reflect a selection bias.[7]

As well, many patients are diagnosed in a secondary or tertiary hospital and their understanding of what they are told is affected by dementia, transient confusion, hearing loss, or language difficulties.

Medical history. Negative or anxiety-provoking experiences with the health care system in early life can leave a person with a fear of physicians.[10]

Premorbid personality and psychological profile. A person with premorbid schizoid (ie, aloof, suspicious) or obsessive (ie, rigid, fixed) traits might be more likely to retreat into denial and withdrawal than a better adjusted person.[5,10] Wool[7] has suggested that deniers are more likely to have been treated for a "nervous condition" at some time during their lives than nondeniers.

A history of risk-taking activity or drug or alcohol abuse might also indicate a tendency to deny.[11] The patient's past methods of coping and defense mechanisms in the face of crises in school, marriage, the workplace, and social relationships might reveal a tendency to use denial as a coping mechanism.

Role of the family. Family members might be reinforcing the patient's denial. They could have their own feelings of denial or guilt, or they might fear the consequences for themselves if the patient's denial is replaced by, for example, depression and consequent increased dependence.

Consequences of the denial. Denial will prevent the patient from making informed decisions. Are there immediate decisions to be made? On the medical front, are any further diagnostic tests or treatments, such as chemotherapy, planned that require informed consent, or is only palliative treatment possible? Concerning finances, does a will need to be drawn up and is business succession decided? Do family issues need to be resolved, such as reconciliation with estranged relations?

We believe that a physician need not always challenge a cancer patient's denial. In assessing the urgency of dealing with the denial, physicians should consider the following.

- Are there any major decisions to be made, as explained above? If so, urgent psychiatric consultation might be indicated. If not, and only palliative care is to be offered, we think that little is to be gained by challenging the denial.[12]
- With what will the patient replace the denial? Hopelessness? Depression? Regression? Will the patient necessarily be any better off for the remaining time, often short, that he or she has left?

Treating the denying patient

Whether or not we think we need to "treat" the denial, we must still treat the

denying cancer patient. In most cases, denial will be replaced eventually by acceptance[2,4]; with appropriate help from a family physician, the patient will usually resolve the conflict.

Physicians should themselves use the words "cancer" or "tumour" in discussions with patients. Do not yourself participate in the denial.

Give patients time to convey their concerns. Needless to say, arguing, or trying to force patients into accepting the diagnosis will not work. People sometimes open up more with non-physicians, such as nurses, social workers, Cancer Society representatives, or chaplains. Physicians should use these resources.

Try to encourage patients to reach their own conclusions in their own way, perhaps by using open-ended questions,[13] such as "What specifically are you concerned about these days?" rather than "Are you worried about anything?" "Why do you think that lump on your breast is getting bigger?" rather than "Do you know why it's growing?"

Keep the relationship constant. Try to defeat the sometimes natural temptation to spend less time with an uncooperative, denying patient. If in a group or resident-teaching practice, try to see the patient yourself each time. These patients are often sensitive to any signs of abandonment.

We use what we call the "C-cubed" approach.

- Give patients time to *convey* their concerns.
- Allow them to reach *conclusions* in their own way.
- Keep the relationship *constant.* ■

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LETTERS

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Keep up the good work

I am so impressed with the October 1993 issue of *Canadian Family Physician* that I feel compelled to write. I congratulate your editorial staff on producing a world class primary care journal. The issue was full of insightful, critically conceived papers that gave me specific answers to burning questions. The papers written by family physicians who researched their problems in my kind of setting were a pleasure to read. I was able to cover the whole issue in about 2 hours. As a result, I am likely to change my practice regarding otitis media, menopausal hormone replacement therapy, and anxiety disorders. The article by the nurse on our role in the new health care team has given me some optimism for the future of health care reform. Keep up the good work.

— James M. Thompson, MD, CCFP(EM)
Chairman, Alberta Family Practice Research Network

Response

Thank you. Your comments make all our hard work worthwhile! Our success with *Canadian Family Physician* is founded on the well-researched and relevant articles we receive from authors and the critical skills of our reviewers. With good material we can build a strong journal.

— Primrose Ketchum
Managing Editor

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